Homeless woman with her child at the Bread and Roses shelter for homeless and battered women in Birmingham, Alabama. The shelter is run by a coalition of church-linked organizations.
ROBERT FOX/IMPACT VISUALS

# Domestic violence

## NATIONAL DIRECTORY OF PROFESSIONAL SERVICES

**CENTER ON CRIME, COMMUNITIES & CULTURE**

*a project of the*
*Open Society Institute*
NEW YORK

signals should be identifiable to service providers from the three major professions (social service, law, and health care) on which this directory focuses.*

**Victim**

- has fears of being injured or harming partner;
- suffers isolation from family, friends, work, religious group, or medical care;
- minimizes the extent and seriousness of injuries;
- protects the abuser from intervention by authorities;
- is reluctant to speak or disagree with partner in his presence;
- suffers repeated injuries, especially those presented as "accidental";
- makes suicide attempts or has homicidal thoughts;
- voices vague complaints to health care professionals or suffers acute anxiety.

**Abuser**

- accuses victim of sexual infidelity;
- is docile and respectful in public but aggressive and cruel in private;
- kidnaps or abuses his children;
- physically or verbally abuses victim in public.

## WHY THE VICTIM STAYS

One of the major areas of controversy in this field, and a question that repeatedly creates frustration on all sides, is the issue of why the victim stays with her abuser.* Family, friends, and service providers sometimes become frustrated when a woman seeks help and professes desire to leave her abuser, only to change her mind later and return to her batterer. The answer to the question "why does she stay?" is not an easy, straightforward one. There are probably as many reasons for why women stay as there are women who are abused. Women find themselves in a unique set of circumstances formed by such influences as childhood exposure to family violence, position in the community, economic factors, and level of understanding of the situation. The abuser's controlling, manipulating behavior is a key factor in any woman's ability or desire to leave. Here is a basic list of common explanations for why many women stay in relationships in spite of being abused:

- desire not to split up the family;
- fear of being killed if she leaves;
- fear of religious sanction;
- concern about inadequate legal protections against further violence;
- expectation of inappropriate or punitive responses from institutions set up to help victims;
- lack of enough money to move out;
- control the batterer maintains over the victim's life.

Half of all homicides of female spouses or partners are committed by men after the couple separated.* Fifty percent of all homeless women and children in the United States are fleeing domestic violence. Lastly, when a battered woman leaves her abuser, there is a 50 percent chance her standard of living will drop below the poverty level. A battered woman may not know these particular facts, but she is often aware of the consequences to her if she were to leave her batterer.

Battered women who decide to leave their abusers can turn to friends, family, or women's shelters for refuge. Every state has a domestic violence coalition office that serves as a resource for local shelters, heightens public awareness of the issue, and makes referrals for women in crisis. Local shelters may be large or small buildings within the community that may or may not offer a range of services to women and their children depending on outside funding. Privacy and confidentiality are maintained and strict rules are enforced in order to guarantee the residents' safety.

## HOW TO GET HELP FOR VICTIMS

The following is a general description of the steps a battered woman must follow in order to be placed in a shelter. First, she must get away from her abuser long enough to be able to

**Project for Domestic Violence Reform**

*Phone:* (302) 577-2200, ext. 3098

The Project for Domestic Violence Reform offers support and information to victims going through the court process, including referrals, accompaniment to hearings, legal services, transportation assistance and some emergency funding.

**Project Target, Delaware Center for Justice**

*Phone:* (302) 658-7174

Project Target offers assistance to domestic violence victims over age 50, including home visits, medical and court accompaniment, counseling, long-term follow-up, and referrals.

## DISTRICT OF COLUMBIA

**D.C. Hotline**

P. O. Box 57194
Washington, DC 20037
*Phone:* (202) 223-0020
*Crisis:* (202) 223-2255

**House of Imagene**

P. O. Box 1493
Washington, DC 20013
*Phone:* (202) 797-7460

**House of Ruth—Herspace**

651 10th Street, NE
Washington, DC 20002
*Phone:* (202) 347-0737
*Crisis:* (202) 347-2777

**My Sister's Place**

5 Thomas Circle, 4th Floor
Washington, DC 20005
*Phone:* (202) 986-1476
*Crisis:* (202) 529-5991



**Whitman-Walker Clinic Victim Services**

1407 S Street NW
Washington, DC 20009
*Phone:* (202) 797-4447

## FLORIDA

**Abuse Counseling & Treatment, Inc.**

P. O. Box 60401
Ft. Meyers, FL 33906
Ph (941) 939-2553
*Fax:* (941) 939-4741
*Crisis:* (941) 1939-3112

**Aid to Victims of Domestic Assault**

P. O. Box 667
Delray Beach, FL 33447
*Phone:* (561) 265-3797 or (800) 355—8547
*Fax:* (561) 265-2102
*Crisis:* (561) 265-2900

**Another Way**

20 South Columbia Street
Lake City, FL 32025
*Phone:* (904) 755-5994
Fax:(904) 755-4519
*Crisis:* (800) 732-2999

**Bay Area Legal Services**

700 Twiggs Street, Suite 800
Tampa, FL 33602
*Phone:* (813) 232-1222

**C.A.R.E. of Charlotte County, Inc.**

P. O. Box 234
Punta Gorda, FL 33951
*Phone:* (941) 639-7079
*Fax:* (941) 6397079
*Crisis:* (941) 627-6000


Child welfare worker requesting that a child be removed from its parents because of abuse or neglect.
RICHARD BERMACK/IMPACT VISUALS



## INTERNATIONAL ORGANIZATIONS

**International Association of Chiefs of Police**

Alexandria, VA 22314-2357
*Phone:* (703) 836-6767
*Fax:* (703) 836-4543
*URL:* http://www.policeforce.org

Law enforcement professionals have turned to the IACP for direction in using new criminal justice technologies and developing effective crime-fighting strategies for over 100 years. Members receive the IACP monthly publication, *Police Chief*, a series of publications for professional education, *Training Key*, and *Policy Review Newsletter*. The organization holds an annual conference, shares legislative information, and may offer training workshops. Their research program has held a series of annual summits on pressing law enforcement issues, including *Murder in America*, *Youth Violence*, and *Family Violence*, which specifically addressed children who witness domestic abuse. You may request a copy of the policy recommendations from the summits by contacting the IACP directly.

## NATIONAL ORGANIZATIONS

**Battered Women's Justice Center**

PACE University School of Law
78 North Broadway
White Plains, NY 10603
*Phone:* (914) 422-4069
*Fax:* (914) 422-4069
*URL:* http://orion.law.pace.edu/bwjc/bwjcmai4.htm

The Battered Women's Justice Center at Pace University was created in 1991 as the first university-based center in the country to train lawyers in handling cases involving battered women. The Center teaches lawyers and prosecutors, supports the provision of pro bono

incidents of domestic violence-related injury assessed by the National Crime Victimization Survey, an ongoing household survey of violence victimization.[14] Such lack of consensus provides further evidence of how much education, training, and commitment to the issue of domestic violence is still needed.

The reality that women go to their physicians with injuries directly resulting from domestic abuse is not new. A study of 520 women who were admitted to the Yale-New Haven emergency room in the late 1970s showed the following:[15]

- 1 in 4 battered women attempted suicide at least once*
- 1 in 7 battered women reported alcohol abuse**
- 1 in 10 battered women reported drug abuse †
- 1 in 7 battered women were eventually admitted to a state mental hospital ††

At the time of the New Haven study, physicians generally provided immediate medical intervention for acute physical crises such as open wounds and suggested treatment for the psychological manifestations of battering.‡ Emergency room providers rarely made referrals to shelter or domestic crisis intervention such as is now standard procedure in hospitals throughout the country.

As Schulman reported, "Abused women who hesitate to call police or social workers for help will use medical services

* This is a rate 8 times higher than among non-battered women; (Stark & Flitcraft, p. 12)

** This is a rate 15 times higher than among non-battered women; (Stark & Flitcraft, Ibid.)

† This is a rate 6 times higher than among non-battered women; (Ibid.)

†† This is a rate 15 times higher than among non-battered women; (Ibid.)

‡ Nearly 25 percent of the battered women who presented with injury were prescribed minor tranquilizers or painkillers as compared with only 9 percent of non-battered women with injury. Statistics for psychiatric referrals were nearly as disproportionate: only 4 percent of non-battered women were referred for some type of psychiatric care whereas battered women were given psychiatric referrals 15 percent of the time. (Stark, E. & Flitcraft, A. (1996). *Women at risk: Domestic violence and women's health*. Thousand Oaks, CA: Sage Publications, Inc., p. 13.)



when they are injured."[16] In many cases, physicians are the first point of contact for battered women who seek help. The intake interview in the emergency room, clinic or doctor's office can therefore, be critical, particularly in those cases where a woman has a history of reporting to her physician with generalized complaints but no visible injuries. It is crucial that the interview be held without the presence of the woman's spouse or partner and that the physician show concern, respect, and compassion for his or her patient in order for the patient to feel comfortable enough to confide the abuse to her doctor.

To guide them through the intake interview of patients who appear to have been abused, health care providers can turn to several good resources. Salber and Taliaferro's book, *The Physician's Guide to Domestic Violence*[17] contains a concise, basic explanation of the physical manifestations of abuse. Melvin and Brunton (1995) published a straightforward article, *Domestic Violence: The Physician's Role*,[18] that we also recommend. The authors use a case study format and simple algorithms to conceptualize the physician's medical decision-making processes. Specific, unthreatening questions that physicians may ask to determine the etiology of injury or discomfort make this article particularly worthwhile. A thorough discussion of diagnosis and treatment protocols is beyond the scope of this directory. However, some key physical and psychological indicators of abuse that should be recognizable to practicing physicians are listed here for reference, along with the most relevant medical specialty for each injury.

| PHYSICAL MANIFESTATIONS | MEDICAL SPECIALTY |
|---|---|
| retinal detachment | ophthalmology |
| orbital blow-out fractures | ophthalmology |
| facial lacerations & fractures | otolaryngology & maxillofacial surgery |
| skull fractures | neurosurgery |
| subdural & epidural hematomas | neurosurgery |
| spinal chord injuries | neurosurgery |
| functional gastroenteritis | gastroenterology & general practice |

## MANDATORY REPORTING STATUTES

| STATE | FIREARM WEAPON | NO FIREARM WEAPON | ILLEGAL ACT | ACT OF VIOLENCE | GRAVE INJURY | INTENTIONAL INJURY | SEPARATELY ADDRESSES DOMESTIC VIOLENCE | NO STATUTES FOUND |
|---|---|---|---|---|---|---|---|---|
| AL, LA, SC, WA, WY | | | | | | | | X |
| AK | X* | X† | | | X† | X† | | |
| AZ | X* | X* | X† | | X† | | | |
| AR, NV, OR | X† | X† | | | | X† | | |
| CA | X* | | X*‡ | | | | X* | |
| CO | X* | X† | X* | | | X† | | |
| CT, ME, MO, SD, TX, VT | X* | | | | | | | |
| DE, MD, MI, MT, NJ, VA | X* | X* | | | | | | |
| DC, MA, MN | X* | X† | X† | | | | | |
| FL | X* | | | X* | | | | |
| GA | | | | | | X* | | |
| HI | X* | X* | | X† | X† | X†§ | | |
| ID | X† | X† | X*¥ | | | X† | | |
| IL, WI | X* | | X* | | | | | |
| IN, KS, NY | X* | X† | | | X† | | | |
| IA | X† | X† | X† | | X† | | | |
| KY | | | | | | | X* | |
| MI, TN | X* | X* | | X* | | | | |
| NE | | | X† | X† | | | | |
| NH | X* | | X* | | | | X*( | |
| NM | | | | | | | X* | |
| NC | X* | X† | X† | X† | X† | | | |
| ND, PA, UT | X* | X* | X* | | | | | |
| OH | X* | X* | X† | X† | X† | | | |
| OK | | | X* | | | | | |
| RI | X* | | | | | | X*# | |
| WV | X† | X† | X† | | | | | |

### LEGEND

- * Reporting is mandated.
- † Reporting is mandated contingent on presence of other element(s).
- ‡ Specifies 24 crimes comprising "assaultive or abusive conduct."
- § Does not state "intentional," but "sustained in suspicious or unusual manner."
- ¥ Felony only.
- ( Provides limited exception from mandatory reporting for survivors of abuse and sexual assault.
- # Reporting for data collection only.

From "Laws Mandating Reporting of Domestic Violence: Do they promote patient well-being?" by A. Hyman, D. Schillinger, and B. Lo, June 14, 1995, *Journal of the American Medical Association, 273* (22), p. 1783. Copyright 1995 by the American Medical Association. Reprinted with permission.

## TABLE 3: PSYCHOSOCIAL AND MEDICAL HISTORY • *CONTINUED*

| | TOTAL SAMPLE (*n* = 1826)* | PATIENTS NOT CURRENTLY ABUSED (*n* = 1718)* | CURRENTLY ABUSED PATIENTS (*n* = 108)* | PREVALENCE† | CRUDE PREVALENCE RATIO (95% CI)‡ | P VALUE | ADJUSTED PREVALENCE RATIO (95% CI)‡ |
|---|---|---|---|---|---|---|---|
| | *n* | *n* (%) | | % | | | |
| **MEDICAL HISTORY** | | | | | | | |
| **Ever attempted suicide** | | | | | | | |
| No | 1655 | 1571 (95.0) | 84 (78.5) | 5.1 | 1.0§ | <0.001 | 1.0§ |
| Yes | 105 | 82 (5.0) | 23 (21.5) | 21.9 | 4.3 (2.8 to 6.5) | | 2.3 (1.3 to 4.7) |
| Missing | 66 | 65 | 1 | | | | |
| **Emergency department visits in past 6 months** | | | | | | | |
| 0 | 1357 | 1288 (77.0) | 69 (65.1) | 5.1 | 1.0§ | 0.005 | |
| 1 | 422 | 385 (23.0) | 37 (34.9) | 8.8 | 1.7 (1.2 to 2.5) | | |
| Missing | 47 | 45 | 2 | | | | |
| **Ever had miscarriage** | | | | | | | |
| No | 1392 | 1318 (77.5) | 74 (69.2) | 5.3 | 1.0§ | 0.046 | |
| Yes | 415 | 382 (22.5) | 33 (30.8) | 8.0 | 1.5 (1.0 to 2.2) | | |
| Missing | 19 | 18 | 1 | | | | |
| **Ever been hospitalized for an emotional or mental problem** | | | | | | | |
| No | 1730 | 1629 (96.4) | 101 (94.4) | 5.8 | 1.0§ | 0.290†† | |
| Yes | 67 | 61 (3.6) | 6 (5.6) | 9.0 | 1.5 (0.7 to 3.4) | | |
| Missing | 29 | 28 | 1 | | | | |
| **Number of lifetime operations** | | | | | | | |
| 0 | 256 | 235 (14.1) | 21 (20.6) | 8.2 | 1.0§ | 0.247†† | |
| 1 | 364 | 346 (20.8) | 18 (17.7) | 5.0 | 0.6 (0.3 to 1.1) | | |
| 2 | 361 | 335 (20.1) | 26 (25.5) | 7.2 | 0.9 (0.5 to 1.1) | | |
| ≥3 | 784 | 747 (44.9) | 37 (36.3) | 5.4 | 0.7 (0.4 to 1.1) | | |
| Missing | 61 | 55 | 6 | | | | |
| **Abused as a child** | | | | | | | |
| No | 1434 | 1380 (80.7) | 54 (50.0) | 3.8 | 1.0 | | |
| Yes | 383 | 330 (19.3) | 53 (49.5) | 13.8 | 13.7 (2.6 to 5.3) | | |
| Missing | 9 | 8 | 1 | | | | |

* Totals fluctuate for individual variables because of missing data.

† Percentage of the total sample who were experiencing current abuse within each response category.

‡ Prevalence ratios were used in preference to odds ratios because odds ratios can produce slightly inflated estimates of the effects of factors. Crude prevalence ratios were derived by dividing the current abuse prevalence in one response category of a variable by that in the reference response category. Adjusted prevalence ratios are only presented for variables used in the final clinical model.

§ Reference group for comparison purposes.

‖ Symptom checklist subscales were divided into approximate thirds.

¶ Indicates that the patient scored in the upper third of the categorized versions of either the anxiety, depression, somatization, or interpersonal sensitivity (low self-esteem) subscales.

** Ever used street drugs, had a score of 2 or more on the CAGE questionnaire for alcohol abuse, or ever had a drinking problem.

†† Not significant ($p \geq 0.05$).

One possible explanation for this difference is the methods for measurement. We used a relatively strict definition of abuse that required physical violence or coerced sexual activities and excluded pure verbal abuse; however, other studies have used a similarly strict definition[12,39]. Investigators of one study have claimed that a questionnaire is less likely to detect abuse than a personal interview by a nurse[39]. That study, however, compared reported rates from questionnaires that were completed by patients in a public waiting room and that became part of their medical records with reported rates from personal, confidential interviews that were conducted in a private setting. In fact, the previously cited study in a primary care setting[12], which reported a higher prevalence rate than we found, also used anonymously completed questionnaires. The relatively low prevalence rate found in our study is most likely due to the older age and higher socioeconomic status of the patients in our study; these characteristics were associated with a lower prevalence of abuse in our study and in some previous studies[3,4]. In fact, 14% of women aged 18 to 35 years, 14% with annual family incomes less than $10 000, and 22% receiving medical assistance or no health insurance reported current abuse in our study.

In our study, the presence of many specific physical symptoms was associated with an increased risk for current abuse. However, some symptoms (face pain, choking sensation, falls, and back pain) were not associated with a higher prevalence of abuse; this is surprising because the face, neck, and torso are considered to be frequently involved in abuse[40]. Although our study confirmed an increased prevalence of depression, anxiety, and previous suicide attempts in currently abused